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## IN THIS ISSUE




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# End-of-life discussions portrayed as first step toward death panels

*Industry concerned that misinformation reflects negatively on hospice*

"Stop the death panels" became a rallying cry for opponents of health care reform when one component of a bill was reimbursement for end-of-life planning discussions between physicians and patients.

Unfortunately for hospice providers and physicians, the reimbursement for end-of-life discussions is no longer part of the proposed bill under consideration, but more importantly, hospice leaders are concerned that discussions between patients and physicians have been portrayed negatively.

"This type of media attention increases the risk that people will associate end-of-life discussions and hospice care as something they don't want," says **Deborah Jaques**, executive director of the Oregon Hospice


### EXECUTIVE SUMMARY

When one health care reform bill allowed physician reimbursement for end-of-life planning consults, opponents said it was an effort to limit health care to certain patients or a first step to euthanasia. Providers are concerned that response can negatively affect the perception of hospice. The good news is that many communities have embraced end-of-life care planning and are demonstrating its value in improved care and reduced costs.

- Oregon reports that 80% of its residents have executed an advance directive, living will, or Physician Order for Life-Sustaining Treatment (POLST) document.
- Pre-planning care has meant that 46% of all Medicare patients who died chose hospice for end-of-life care.
- A collaborative effort in La Crosse, WI, has resulted in 95% of all senior citizens completing an advance directive.

Association in Portland. A negative public portrayal of end-of-life discussions might cause individuals to hold back from having important discussions about the health care decisions they will make at different stages of their lives, she says. "Being able to ask yourself if hospice care will help you or a family member at some point in their life is critical to being able to make a well-informed health care decision," she says. "Although there is a saying that there is no such thing as bad publicity, I believe this is bad for our industry, because the negativity might prevent an individual from considering hospice when it might be the right decision." **(For more about end-of-life conversations, see "Discussions on end-of-life issues improve quality of life, save $$$," *Hospice Management Advisor*, July 2009, p. 73.)**

The irony of the negative publicity is that the reimbursement was for a health care planning discussion to be held no more than every five years between a physician and a patient, says Jaques. "Many physicians already have these discussions with patients when they face changes in their health status, but there is no mechanism to reimburse the physician specifically for this type of consultation," she explains. Inclusion of specific reimbursement for a health care planning consultation would have increased the awareness of the importance of planning ahead, she adds.

Planning for care at different stages of life is common in Oregon, even without specific reimbursement for the consultation. Almost 80% of Oregonians have some sort of document that directs their health care decisions.[1] Being able to think about how they want to live the last months or days of their lives enables people to consider hospice and learn more about the services that hospice provides, says Jacques. "In our state, 46% of all Medicare patients who die are in hospice care at the time of their death," she says. "This means that these patients are receiving care to minimize their pain, make them comfortable, and help their families through the process.

"It is also proven that hospice care saves money compared to patients who do not receive hospice care," says Jaques. A study by Duke University found that hospice care reduced Medicare costs by about $2,300 per patient, saving more than $2 billion per year, she says.[2]

## POLST provides actionable orders

Although advance directives and living wills are important documents to designate health care representatives and indicate actions to take if certain situations occur, the document most often recommended for people who have a life threatening illness or are diagnosed as terminally ill, is a Physician Orders for Life-Sustaining Treatment (POLST), says Jaques.

"A POLST is an actionable, immediate physician's order that an EMT or emergency room physician can act upon," she explains. Even if the patient's wish is to limit life-sustaining treatment, the EMT is required to provide care in the absence of a physician's order, she says. "A POLST enables the EMT to follow the patient's wishes for treatment," Jaques adds. **(See p. 123 for more information about POLST.)**

POLST and living wills also are prevalent in La Crosse, WI, where 95% of senior citizens have a document designating their desires for health

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care at the end of life. This focus on advance care planning means more hospice care and less hospitalization while dying, which results in a significant savings. Medicare pays about $18,000 for the last two years of a beneficiary's life in La Crosse compared to nearly $64,000 for end-of-life care in Miami.[3]

The high rate of advance care planning is the result of a program that started in 1991 with leaders of the two local health systems agreeing to collaborate on an educational program that encouraged physicians, other providers, and seniors to have a conversation about health care wishes, says **Bernard "Bud" Hammes**, PhD, ethics consultant, director of medical humanities, and director of Respecting Choices, a community program to promote advance care planning, at Gundersen Lutheran Medical Foundation, La Crosse, WI. **(For more information about Respecting Choices, see resource box, p. 125.)** Not only did the city's two health systems agree to cooperate but as the program Respecting Choices developed, nursing homes, home care agencies, and hospices not affiliated with the health systems used the model to talk with patients and encourage conversations about advance care planning.

"We did not just focus on completing the document," Hammes points out. "We encouraged conversations between health care providers and patients, and patients and their family members." Physicians and other providers were taught how to facilitate a conversation that helps patients make informed decisions and weigh treatment options at different points in their health, he explains. "Timing is everything. You do not want to have a conversation about end-of-life decisions when a person's illness in under control," he says. "It is an ongoing process in which the physician or health care provider is constantly checking with the patient to see if the document should be updated."

After the provider talks with the patient, it is critical that the patient talk with family members to make sure that everyone understands the decisions and the reasons for those decisions, he adds.

Advance planning ensures patients and their families know all options available to them and saves money, Jaques says. Addition, quality of life at the end is enhanced, she says. "These are choices that we should want to make for ourselves, because the real issue is: 'What do you want to happen when you die?' because none of us is getting out of this alive," she says.

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# Document ensures directions are followed

The Physician Orders for Life-Sustaining Treatment (POLST) form has been in use in Oregon since 1995, four years after the initiative was begun in the state. Since 1995, some form of the POLST program has been adopted in more than 30 states.

"Each state differs in the level of implementation, but it is encouraging to see a document that is actionable and ensures the respect of the patient's wishes reaching so many people," says **Deborah Jaques**, executive director of the Oregon Hospice Association in Portland. Although POLST has been in use for a long time in Oregon, changes have been made to improve upon the program, she says.

"Our POLST is a bright pink form that is easily found in any medical chart," Jaques points out.

Patients who are in their homes when an emergency medical technician (EMT) is called or who enter the emergency department unexpectedly, also

## Need More Information?

**For more information about incorporating Physician Orders for Life-Sustaining Treatment (POLST)** into advance care planning in your community or agency, go to www.polst.org. The web site has information on how to set up a program, educational materials, and resources for legal, regulatory, and clinical issues. Educational materials and resources such as POLST forms and wallet cards used by different states are available for purchase as well.

have ways to alert health care providers to their wishes, even if they are not able to communicate, Jaques says. "The refrigerator is the most common place to post the POLST, so EMTs know to look there for a POLST," she says. "We also distribute wallet cards for patients to keep with them."

Beginning January 2010, all Oregon residents with a POLST will have the option of including their document on a statewide database that can be accessed by any first responder, says Jaques. "This will make it possible for an emergency room physician or an EMT to look up the information even if the form is not available," she adds.

In La Crosse, WI, the POLST also is a key component of the communitywide program to promote advance health care planning, says **Bernard "Bud" Hammes**, PhD, ethics consultant, director of medical humanities, and director of Respecting Choices, Gundersen Lutheran Medical Foundation, La Crosse. First responders in the city also have access to all POLST documents because the two health systems in the area have sophisticated electronic medical records systems that enabled the development of a database that provides access to health care providers, no matter which health system with which they are affiliated. "If we are trying to respect a patient's wishes, we have to make sure that all health care providers will know what those wishes are," he says. ■

# Program enables patients to make informed decisions

*Various stages of health require different planning*

An innovative program that encourages physicians and other providers to facilitate the tough conversation about care at the end of life has resulted in 95% of the senior citizens in La Crosse, WI, having advance care directives that guide their care. Because most of those directives are Physician Orders for Life-Sustaining Treatment (POLST) forms, the wishes of the patient are carried out with no questions because they are physician orders, not just a legal document.

More important than the fact that the documents are completed and signed by seniors is the fact that people are discussing their health care wishes with providers and family members, says **Bernard "Bud" Hammes**, PhD, ethics consultant, director of medical humanities, and director of Respecting Choices, Gundersen Lutheran Medical Foundation, La Crosse, WI.

"When the health care providers of this community came together to create the Respecting Choices program to promote the importance of advance care planning, we focused on the process, not just the documents," Hammes says.

Although completion of living wills, health care power of attorney, and other types of advance directive documents was the ultimate result of the community effort, the focus was on facilitating conversations that provided information and options to people and their families. "We wanted to help patients and their families understand all of the issues and talk about decisions they were making," Hammes says.

A key strategic decision made by the task force comprised of leaders from the two health systems in the city was that no program would work if only physicians were involved, says Hammes. Physicians are a key component, but they are trained to diagnose and treat patients, he says. Many of them are not comfortable having discussions about end-of-life care that means no more curative treatment, he explains. "We created the new role of advance care planning facilitator throughout the community," Hammes says. "Facilitators undergo a training program that enables them to work with physicians to guide patients and their families through their decisions."

Advance care planning facilitators don't have to be clinicians, Hammes points out. "We trained social workers and chaplains in addition to nurses," he explains. Initially the 16-hour training program was offered four times per year, but it is now offered twice each year because there are fewer people that need training. "We train people from the health systems for free because the two organizations are underwriting the costs of the program, and we charge $100 per person

for people from nursing homes or organizations outside the health systems," Hammes says.

### *Facilitators lead with no bias*

The training focuses on how to facilitate a conversation about a patient's health status and options for future treatment without imposing the facilitator's bias on the conversation, says Hammes.

"We are always asked what we would do in certain situations when we are talking about difficult decisions that must be made, and this gives us the opportunity to have undue influence," he says. "After undergoing training, it becomes easier to explain that everyone has different values and goals, so everyone's decisions, including my own, may not be the right decisions for someone else."

The facilitator leads the patient through a discussion of personal values and goals and then discusses options that the patient can consider.

Although POLST is the document used in La Crosse since 1997, it is not used for all patients in the community, points out Hammes. "Timing is critical to having a successful discussion about advance care planning," he says. "Advance care planning happens in stages throughout a patient's life."

A basic plan that is comprised of designation of a power of attorney for health care is appropriate for younger, healthier patients, Hammes says. A more detailed, disease-specific plan is needed for a patient with a condition that means more risk of health care crises, such as advanced chronic heart failure. The final stage of planning is development of the POLST for patients who are at the stage where decisions regarding life support and extraordinary measures are realistic, he says.

"You have to time conversations to meet the needs of the individual, because no one can realistically discuss end-of-life decisions when they are young and healthy, so you address what is most important to them at the time," recommends Hammes. Although most patients completing advance directives are referred to a facilitator by a physician, home health representative, or nursing home staff member, there are some members of the community who choose to complete the documents with their attorneys. "We have worked with the local bar association to ensure that the same documents are used and that access to the documents is available through our database," he says. Attorneys also have access to facilitators if their clients want to consult them, he adds.

#### Need More Information?

**For more information about Respecting Choices**, go to www.respectingchoices.org. The web site contains information about consultations, training courses, printed materials, and research.

Hammes and other members of the Respecting Choices program are helping other communities set up similar programs. "We do have an advantage in our community because there are only two health systems and physicians are closely aligned with one or the other system," he says. "This made collaboration easier, but it doesn't mean that our model is the only one that will work."

An eight-hospital system in Illinois is taking the Respecting Choice approach as a standard of care within its system, a single-hospital city in another state is adopting the program, and the medical societies in Minneapolis and St. Paul in Minnesota are heading up the effort to become the first major metropolitan area to adopt the approach, he says. "The pilot program in Minneapolis and St. Paul is beginning, but two of the five health systems involved have been using some form of the program, so some participants have a head start on implementation," he says. ■

## Reduce risk with protocols, good hiring practices

Risk management in hospice presents challenges not faced by most health care providers, but there are steps that agencies can take to reduce risk and provide protection from lawsuits and costly claims.

"A hospice's risk management needs will differ depending on the services provided," points out **Marie F. Gaudette**, CIC, CPIW, vice president of Smith Bell & Thompson Insurance in Burlington, VT. "Professional liability coverage differs if you provide services in your own facility and have control over people and equipment compared to services providing services only in the home," she points out. "If you are in the patient's home, you have no control over ease of access, cleanliness, or physical conditions, so you are at more risk of injury to patients and employees."

## EXECUTIVE SUMMARY

Cutting overhead costs is one way to address the financial crunch, and paying attention to risk management can ensure that no surprise expenses are incurred. To help reduce the cost of professional and general liability as well as workers' compensation premiums, and to help reduce the risk of claims, do the following:

- Perform criminal background checks and drug screens on employees before hiring.
- Offer lifting technique training, and set weight limits for lifts.
- Require continuous communication between home-based staff and supervisors.
- Maintain contact between patients, families, and supervisors.

A hospice can ensure the right liability coverage and reduce premiums by addressing some key issues for home care services, says Gaudette. "Falls, positioning, and manipulation injuries represent the highest number of claims from patients and employees," she says. Minimize the risk of these claims by conducting an environmental safety assessment upon each admission, Gaudette says. *(Editor's note: To see a copy of a safety assessment checklist developed by the New Jersey Department of Health and Senior Services, go to www.state.nj.us/caregivernj/documents/checklist.pdf.)*

"If there are significant safety issues such as a lack of safety bars in bathroom, a need for a bed with rails, repairs made to access to house, be sure to document the items that the patient and family must address," she says. "If the patient agrees to make necessary changes but does not, then the hospice must explore other options such as moving the patient to a safer environment such as a nursing home."

Recommending a nursing home or other facility might also be the suggestion if the patient is in a setting that the hospice staff believe to be unsafe, Gaudette adds.

Minimize risk to employees by establishing protocols that ensure employees are able to handle their job responsibilities safely, suggests **Sid Rockliss**, chief financial officer of VNA of Chittenden and Grand Isle Counties in Colchester, VT. All of his employees undergo a pre-employment physical to ensure that they are capable of handling all aspects of their jobs, Rockliss says. "We have a job description for each of our clinical staff that is specific to their responsibility," he says. "A physical therapist has input on weight that employees can lift and provides training on lifting techniques to all clinical staff members."

"We are at highest risk for workers' compensation claims in the first six months of employment for our licensed nursing assistants, so we make sure they get lifting technique training and extra supervision during this time," says Rockliss. Not only are lifting techniques taught during orientation, but also each nursing assistant must pass competency assessments before beginning patient care, he adds. Equipment such as mechanical lifts are provided in homes where the patient's weight is more than an assistant can safely handle. If necessary, two assistants are assigned on some visits, Rockliss says. "It is easier to provide equipment than schedule two assistants," he admits.

The additional training and supervision have paid off for his VNA, says Rockliss. "Workers' compensation premiums are based on every $100 per salary paid by the agency, and over the past six years, our premiums have dropped, even though our work force and salaries have increased," he points out.

### Increase supervision of home-based staff

Another challenge for hospices is the increasing charges of employee theft and abuse, says Gaudette.

"An agency can minimize the risk of employees stealing from patients or submitting fraudulent visit reports by taking steps before hiring the employee," she says. The following steps should be taken prior to any hire:

- conduct federal and local criminal background check;
- contact references and, if possible, ask for recommendations in writing;
- require drug and alcohol screenings of every potential employee;
- verify licenses to ensure they still are valid.

Even if you conduct drug and alcohol screenings prior to employment, be sure your policies state that you can mandate a screening at any point during employment as well, says Gaudette. "You should always have the option to screen if there is any suspicion of drug use," she explains.

To avoid liability, be careful not to ask your staff members to perform tasks that are outside the scope of their training, warns Gaudette. "Because of earlier discharge from hospitals and

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For more information about reducing risk, contact:

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the increased complexity of care needed for patients in the home, some agencies are relying on aides and assistants to provide care for which they are not trained or licensed," she says. Not only is Medicare not paying for medical errors such as preventable bed sores, preventable infections, and injuries caused by falls, but also patients and families have valid claims against the agencies in these cases if the care was provided by an unqualified staff member, Gaudette points out. "Make sure that staff members are qualified to perform their jobs, and make sure employees have access to clinicians who can perform the tasks," she advises.

Because hospice home care staff work without regular supervision, communication between staff and supervisors is important, says Gaudette. "Supervisors should be talking with staff members regularly to ask about patients or job-related concerns," she says. Supervisors also should interact with patients and family members at a time they can talk without the regular caregiver in attendance to promote open communication, Gaudette says. Not only do those conversations give the supervisor a chance to identify strengths and weaknesses of employees, but it also gives the family a chance to express concerns they might not express to the day-to-day caregiver. "This should happen at the start of care, throughout care, and after care," Gaudette says. ■

# MRSA comes home with more patients

Agencies look to prevent transmission

Methicillin-resistant Staphylococcus aureus (MRSA) is common in most hospitals, but a recent study shows that almost 13% of patient discharged from the hospital to home health care are infected with MRSA.1 (For more on study, see story, p. 129.)

"There has been an increase in the number of patients coming to home health with MRSA," admits Marcia R. Patrick, RN, MSN, CIC, director of infection control for Multicare Health Systems in Tacoma, WA. "In 2000, we typically saw about 7% of patients admitted from hospitals to home health colonized with MRSA; now we see 12%," she says.

The most common patients to have MRSA are patients who are considered "frequent fliers," Patrick says. "Patients with a lot of hospital admissions are more likely to be exposed to MRSA and are more likely to have medical conditions that put them at risk for infection," she explains.

In general, home health agencies are not screening new admissions for MRSA or other multidrug-resistant organisms (MDROs), says Patrick. "At our hospital system, patients discharged from the intensive care unit are screened as are other high-risk patients, so we do know if they have MRSA when admitted," she says. "Other patients who don't receive screening in the hospital are not screened unless we have a problem such as a wound that does not heal."

The difficulty in selecting which patients might require screening at admission is that about half of patients who are colonized with MRSA do not have any symptoms or risk factors, she says.

Although some hospitals do have MRSA screening programs, they don't address all patients, just patients in high-risk areas such as intensive care, says Irena L. Kenneley, PhD, APRN-BC, CIC, professor at Case Western University in Cleveland.

The Association for Professionals in Infection

### EXECUTIVE SUMMARY

A recent study says almost 13% of patients discharged from the hospital to home health have methicillin-resistant *Staphylococcus aureus* (MRSA). Some agencies have seen an increase from 7% to 12% of home health patients with MRSA since 2000.

- Most home health agencies do not screen for MRSA upon admission but will use extra precautions if the patient was diagnosed with MRSA in the hospital or has had MRSA in the past.
- All staff members should use good infection control practices even if the patient is not identified as having MRSA or has no symptoms.

Control and Epidemiology (APIC) Scientific Research Council funded a study to find out the national prevalence of MRSA at U.S. health care facilities in the form of a survey sent to infection control professionals across the country.2 "The APIC MRSA inpatient survey found that the MRSA colonization and infection prevalence in U.S. health care facilities is 46.3 per 1,000 inpatients, which is eight to 12 times higher than previous estimates," Kenneley says. "What has important implications for home health care is that it was also found that 67% of MRSA identified were on medical services, suggesting that MRSA is not focused just in ICU or surgical patients. As for active surveillance cultures, only 28% of the respondents performed them."

Patrick says, "We really can't do a thorough risk assessment for MRSA unless we screen, but implementing a screening program in home health presents some challenges." Not only is reimbursement for the cost of test an issue, but also additional training would be required to ensure that the screening test is conducted properly, she says. "The most commonly used method, swabbing the nose, still requires proper technique to obtain accurate results," Patrick says.

Although her agency does not conduct routine screenings for MRSA or other MDROs upon admission, Judie Truelsen, RN, BSN, interim co-director of Northwest Community Home Care in Arlington Heights, IL, will contact physicians for orders to culture wounds that are not healing to check for MRSA and other organisms, she says.

In the absence of thorough MRSA screening programs for hospitals and home health agencies, the best way to protect patients, family members, and staff members from transmission of MRSA is to assume that everyone is potentially infected, suggests Truelsen. "We teach our staff members to use standard precautions in all patients' homes to prevent the spread of MRSA and any other infection," she says.

Rather than single out MRSA in infection control practices, it works best to expect standard precautions to be followed all of the time, Truelsen says. "This is the best way to develop good habits and practices and makes it much easier to remember what should be done to prevent the spread of any infection," she adds. (For specific precautions taught to staff members, see p. 129.)

Although MRSA patients can be decolonized after initial exposure, they are at risk for contracting MRSA again, Patrick says. "Once MRSA, always MRSA," is the rule followed by her staff.

## Need More Information?

For more information about methicillin-resistant *Staphylococcus aureus* (MRSA) in home care, contact:

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**For more information about multidrug-resistant organisms in nonhospital health care settings**, go to www.cdc.gov/ncidod/dhqp/ar_multidrugFAQ.html.

**For more information about standard precautions**, go to: www.cdc.gov/ncidod/dhqp/gl_isolation_standard.html.

"A patient with MRSA contaminates his or her home, so some areas can't be disinfected," she adds. "A kitchen and bathroom are easy to disinfect, but sofas, chairs, and rugs can't be disinfected so remove all traces of MRSA," Patrick explains. This is another reason that Patrick emphasizes the use of standard precautions in all homes.

Kenneley says, "We will not fix the problem of increasing rates of infection and colonization caused by MDROs overnight." The solutions are not simple given the complex health care delivery system, she says. "Solutions will require increased support for ownership of infection control and prevention not only in home health, but also throughout the entire health care delivery system."

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# Research finds 12% take MRSA home

A recent study shows that 12% of patients discharged from the hospital to home health care are infected with methicillin-resistant Staphylococcus aureus (MRSA).1

The study looked at 1,501 patients who were screened for MRSA prior to discharge to home health care. A total of 191, or 12.7%, of the total number of patients were infected before discharge from the hospital. One year after discharge from the hospital, 75 of the infected patients were clear of the infection.

Household contacts of the 191 MRSA patients also participated in the study. Of these, 36, or 19.1%, acquired MRSA but did not develop an infection. The authors point out that older family members or friends who play a care giving role are more likely to acquire MRSA. Family members who shared a room or a bed with the patient were less likely to acquire MRSA than family members who provide care, so the authors concluded that MRSA is more likely to be transmitted through hand contamination.

The authors recommend that home health staff members and family caregivers use infection prevention methods similar to those used in a hospital setting to prevent transmission of MRSA. This includes hand washing, use of gloves, and disinfection of surfaces that can carry MRSA.

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1. Lucet JC, Paoletti X, Demontpion C, et al. Carriage of methicillin-resistant Staphylococcus aureus in home care settings. Arch Intern Med 2009; 169:1,372-1,378. ■

# Protocols, equipment prevent spread of MRSA

## Infection control training should be ongoing

Although standard precautions are taught to home health employees, the importance of precautions rises with the increasing number of patients coming to home care with multidrug-resistant organisms (MDROs) such as methicillin-resistant Staphylococcus aureus (MRSA).

To combat the spread of MRSA or any other infection from one patient home to another or from a patient to a staff member's family, the employees at Northwest Community Home Care in Arlington Heights, IL, follow very specific infection control protocols, says Judie Truelsen, RN, BSN, interim co-director of the agency.

"Each clinician has a personal protection pack that includes gowns, gloves, masks, an eye shield, and booties," she says. "If an employee knows that the patient requires this level of infection control precautions, they are all prepared," she explains.

Even with patients who may not require employees to wear gowns and masks, nurses always follow a specific protocol to prevent transmission of infection from one patient to another through contact with shared equipment, Truelsen says. "Nurses carry a nonpermeable barrier, a piece of plastic, to place on the surface on which they are placing their nurses' bags," she says. "They also place a barrier on the surface that they might place their stethoscope or other equipment to prevent picking up an organism from the table or other surface."

Before the nurse removes an item from the bag, hands are cleaned with an antibacterial wipe, and any time the nurse reaches back into the bag, hands are cleaned with a wipe, says Truelsen. Before any item, such as a stethoscope, is placed back into the bag, it is wiped with an antibacterial wipe as well, she adds.

Nurses' bags can be a source of transmission, so it is important to pay attention to infection control protocols related to the bags, says Irena L. Kenneley, PhD, APRN-BC, CIC, professor at Case Western University in Cleveland and lead investigator of a study that examined the role of home health nurses' bags in infection control. Even with good infection control precautions, MDROs present additional challenges that require extra precautionary steps, Kenneley suggests. "Enhanced environmental cleaning is vital, stressing the use of dedicated equipment, and leaving the nurses' bag out of the patients' homes," she says.

When identifying what equipment you will leave in the home, don't just focus on items such as pulse oximeters or stethoscopes, suggests Marcia R. Patrick, RN, MSN, CIC, director of infection control for Multicare Health Systems in Tacoma, WA. "The gait belt used by a physical therapist can transmit organisms that live on clothing or other surfaces the belt may touch," she explains. If it is not possible to leave some equipment in the patient's home, develop a process to disinfect the equipment before using it with another patient, Patrick suggests. "MRSA can live on the surface of

the skin, so even blood pressure cuffs might transmit the organism," Patrick says.

"Don't forget items such as rolls of bandage tape, bandage scissors, and other supplies that many nurses will just throw back into their bags," she says. "Whenever possible, leave supplies in the patient's home to be used only for that patient."

Kenneley says, "Educating the clinical importance of MRSA, and in fact, all multidrug-resistant organisms [MDROs], to clinical staff, patients, informal caregivers, and families is a high priority." She suggests that educational emphasis should begin with the following facts:

- Options for treatment are limited.
- MDROs have been associated with increased lengths of stay, increased cost, and increased morbidity and mortality.
- Outcomes are worse patients with resistant organisms that include not only MRSA, but also vancomycin-resistant Enterococcus (VRE), Pseudomonas, Acinetobacter, Enterobacter, E. coli, and Klebsiella pneumoniae.

"A review of standard precautions and contact precautions is also important, along with stressing appropriate hand washing," Kenneley adds. Patients and all family members should be included in the teaching, she suggests.

Patrick says, "We include infection control practices in orientation, but we also have supervisors go on visits with the field staff to observe their techniques." The review of infection control practices is part of every employee's annual assessment, she adds. ■

# The evolving policy on physician-assisted suicide

Calling it "a significant turning point in American society's evolution to empower terminally ill patients with information and choices about how they will die," an article by the director of legal affairs for Compassion & Choices points to four medical professional and health policy organizations that have adopted policy to support physician-assisted suicide.1

Compassion & Choices, however, refers to this as "aid in dying."

The organizations that have adopted such policies, according to the article, include the American Public Health Association, the American Medical Women's Association, the American College of Legal Medicine, and the American Medical Student Association.

"Certainly, if you look at polling across the country, the public support for the choice of aid in dying . . . has certainly grown over time," says Kathryn L. Tucker, JD, director of legal affairs for Compassion & Choices.

Tucker also emphasizes that the choice of aid in dying is something she views "as a medical term of art which refers to a physician who writes the prescription to a mentally competent, terminally ill patient [who] can self-administer to bring about a peaceful death, if they find their dying process unbearable.

"There's a lot of poll data that reflect that, but apart from that is that there's growing support for this intervention in the medical community," she says.

Tucker suggests that the support from these medical organizations in 2008 "is very much tied to an evidence-based review of what has happened in Oregon." Currently, Oregon and Washington allow physician-assisted suicide. There are organizations, however, such as the American Medical Association in Chicago, that do not support physician-assisted suicide.

A third court case, Baxter v. Montana, has been heard by the Montana Supreme Court, and the parties are waiting on that court's decision, perhaps to be decided by the end of the year, Tucker says.

## Going on record

Tucker says she credits the American Public Health Association with "speaking out, because it is a public health issue . . . in a couple of senses."

"One, we know that where aid in dying is not affirmatively legal, it goes on in the back alley, covertly, and that we know from studies that when that back alley practice happens, it's more dangerous for patients, there are more complications, and it's much more stressful for the patient and the family," she notes.

Tucker says by "back alley" practice — a term familiar to pro-choice advocates — she is suggesting that studies that show the practice of physician-assisted suicide "goes on everywhere."

"What we don't know is when it happens covertly, meaning, in an extralegal environment or in an environment where there haven't been boundaries established either by the legislature or by a court decision, then what you have is a completely unregulated, covert practice," she says.

In unregulated environments, Tucker says, you

have physicians who "don't feel comfortable, and in fact, feel fearful about discussing a particular case with a colleague, for example, and so that doesn't happen. And you miss that second opinion, or collegial input, that you might otherwise have," she adds.

Tucker points out that Oregon and Washington require a second physician opinion in a lengthy process toward granting the permission to seek a lethal prescription. "So, you lose that," Tucker says. "You lose the opportunity for really candid and open discussion, where the physician feels comfortable exploring whether the patient has considered a full range of options, such as hospice, aggressive palliative care, etc."

## A bioethicist's perspective

Rosamond Rhodes, PhD, is a professor of medical education and director of bioethics education at Mount Sinai School of Medicine in New York City. In the late '90s, she published an essay titled, "Physicians, Assisted Suicide, and the Right to Live or Die." That essay was included in the book Physician-Assisted Suicide: Expanding the Debate, for which she also served as an editor.

One of the aims of the article, she states within it, is "to show how the concept of a right to life actually supports the case for physician-assisted suicide." There are other essays in the book that offer the polar opposite view of any participation by physicians in contributing to a dying patient's right to end his or her own life.

Rhodes says there are "significant majorities all over the country [that] support allowing people to make these decisions for themselves." She adds that the Patient Self-Determination Act of 1990, a federal law "requires that every state have a mechanism to allow patients to refuse medical treatment, including life-preserving, life-prolonging treatment."

"So, as federal law, we recognize that a patient may require a medical treatment to continue living, and we know that discontinuing the treatment will hasten the patient's death. Yet, people are required — by law — to honor the patient's request," Rhodes says.

In a scenario that many doctors face daily with ventilator-dependent patients by making a decision based on the patient's request to remove the ventilator, there is very little difference with the scenario presented by physician-assisted suicide, she says.

"As far as I'm concerned, there is no significant moral or factual difference between withdrawing life-preserving treatment and any other way of hastening death," Rhodes says.

### Need More Information?

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